



MEDICAL CONSENT AUTHORIZATION FOR MINORS

Please mark the appropriate option below:

Option 1:

_____, I, _____, am the parent/legal guardian/legal custodian (by court order) of the child listed below and there are no court orders now in effect that would keep me from having the power to give another person permission to bring in and consent to care for my child.

(patient name)

(patient date of birth)

Adults that are granted permission to consent to examinations and treatment and granted permission to receive health information about my child:

NAME: _____ RELATIONSHIP: _____

The person named above may consent to the following examination and treatment for my child and may have access to any and all records, including, but not limited to, insurance records regarding any such services. I confer the power of consent freely and knowingly in order to provide for the child and not as the result of pressure, threats or payments by any person or agency. This document shall remain in effect until it is revoked by my written notification to my child's medical and insurance providers, and the person(s) named above.

Option 2:

_____, I, _____, am the parent/legal guardian/legal custodian (by court order) of the child listed below. I give consent to Martin Foot and Ankle to treat my child without an adult present. I am aware that there will not be anything discussed with my child other than the issue address previously. I am also aware that should a medical procedure be needed, I will need to be available to provide verbal consent. This option is only valid for one date of service.
DOS: _____.

(patient name)

(patient date of birth)

In witness of, I have signed my name to this medical consent authorization, on this _____ day of _____
20____ in _____, Pennsylvania.

Printed Name Parent/Guardian/Custodian _____
Parent/Guardian/Custodian Signature _____

Witness Printed Name _____
Witness Signature _____